DEPARTMENT OF HEALTH AND HUN **SERVICES**

PRINTED: 12/15/2016 FORM APPROVED

CENTERS FOR MEDICARE	* & MFDICAID SERVICES		O	<u>MB NO. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495197	B. WING		C 12/08/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BELVOIR WOODS HEALTH C	ARE CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY CORRECT FORT BELVOIR, VA 22060	CTED COPY
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F 000 INITIAL COMMEN	TS	F	000 F. 329 483.45 (d) DRUG REGIM	EN IS FREE FROM

An unannounced Medicare/Medicaid standard survey was conducted 12/6/16 through 12/8/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 56 certified bed facility was 54 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents #1 through #12) and four closed record reviews (Residents #13 through #16).

F 329 483.45(d) DRUG REGIMEN IS FREE FROM SS=E UNNECESSARY DRUGS

- (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--
- (1) In excessive dose (including duplicate drug therapy); or
- (2) For excessive duration; or
- (3) Without adequate monitoring; or
- (4) Without adequate indications for its use; or
- (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced

UNNECESSARY DRUGS

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

A review of the Resident #8's care plan and behavior monitoring sheets were confirmed by the Director of Nursing (DON) on 12/8/16, which stated the behavior, the name, the location and F 329 physician of the resident.

> The nursing staff received refresher training conducted by the Director of Nursing on how to complete behavior monitoring sheets and care plans on 12/16/16.

> 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The Director of Nursing conducted an audit on 12/8/16 of residents who are on Olanzapine/Zyprexa and other anti-psychotics. Any issues that were identified were resolved.

PROVIDER/SUPPLIER REPRESENTATIVE'S S	

Felle Baker

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is defermined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for harding from the following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan and correction is requisite to continued program participation.

UEC 27 2016 ntinuation sheet Page 1 of 17

DEPARTMENT OF HEALTH AND HUM. SERVICES

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			3 Address what measures will	ne nut into place

F 329 Continued From page 1

by:

Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a resident was free from unnecessary drugs for one resident of 16 residents in the survey sample, Resident # 8.

The facility staff failed to monitor behaviors for the use of Olanzapine (1), an antipsychotic medication for Resident # 8.

The findings include:

Resident # 8 was admitted to the facility on 6/3/09 with diagnoses that included but were not limited to: depressive disorder, gastroesophageal reflux disease (2), Parkinson's disease (3), atrial fibrillation (4), paranoid schizophrenia (5), heart disease, chronic kidney disease and dementia (6).

Resident # 8's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 10/11/16 coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, 2 being severely impaired of cognition for daily decision making. Resident # 8 was coded as requiring extensive assistance of one staff member for activities of daily living. A review of Section E "Behaviors" coded Resident # 8 as not exhibiting any behaviors.

The POS (Physician's Order Sheet) dated December 1, 2016 for Resident # 8 documented, "Olanzapine 2.5 MG (milligram) Tablet. Give 1.25 mg orally at bedtime for schizophrenia. Order Date 0913/2015."

"Monitor behavior episodes and attempt to

3. Address what measures will be put into place F 329 or systemic changes made to ensure that the deficient practice will not recur.

A behavior reference guide has been developed that indicates what behaviors should be monitored and documented and what follow up actions should be taken. The nursing staff will be educated on the reference guide by the Director of Nursing. (See Appendix A). Education on behavior monitoring on Olanzapine/Zyprexa and other anti-psychotics was completed on 12/16/16.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing, or designee, will audit behavior monitor sheet and electronic Treatment Administration Record (eTAR) of residents with Olanzapine/Zyprexa and other anti-psychotics for compliance with behavior monitoring to confirm-documentation includes residents name, location, physician and specific behavior. If issues are identified during the audit process, then coaching, and corrective action will occur.

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Facility ID: VA0028

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F 329	antipsych (antipsyc Consider location, t and situations. Doo	ng cause and side effects of hotic) meds (medications). ime of day, persons involved cument nurse's notes for noted	F	The Director of Nursing, or des the results of the weekly audit Assurance and Performance In Meetings for 3 months.	at the Quality
	behaviors and inter	ventions as needed."		At the conclusion of the three	months, the QAP

The physician's progress notes for Resident #8 dated 9/1/16, 10/14 16 documented, "Schizophrenia - Zyprexa (Olanzapine (7)"). The physician progress note dated 11/4/16 documented, "Schizophrenia -Olanzapine."

The eMAR (electronic medication administration record) dated September 1, 2016 through December 6, 2016 for Resident # 8 documented, "Olanzapine 2.5 MG (milligram) Tablet. Give 1.25 mg orally at bedtime for schizophrenia. Start Date 09/13/2015." Further review of the eMAR revealed Resident # 8 received an Olanzapine tablet at 8:00 p.m. every day from 9/1/16 through 12/6/16.

The eTARs (electronic Treatment Administration Record) dated October 1, 2016 through December 6, 2016 for Resident # 8 documented, "Monitor behavior episodes and attempt to determine underlying cause and side effects of antipsych (antipsychotic) meds (medications). Consider location, time of day, persons involved and situations. Document nurse's notes for noted behaviors and interventions as needed every shift related to Paranoid Schizophrenia. Start Date: 1/13/2016." The eTARs dated 9/1/16 through 12/6/16 revealed that Resident # 8 did not have any behaviors. Further review of the eTARs failed to document Resident #8's targeted behaviors for the use of Olanzapine.

Resident #8's care plan dated 12/15/2014 was

committee will re-evaluate and initiate any necessary action or extend the review period.

The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of Correction and addressing and resolving variances that may occur.

5. Include dates when the corrective action will be completed.

All corrective actions completed by 1/6/17.

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resident has a po (related to): delus to) schizophrenia Under "Intervention behavior episode underlying cause persons involved needed. Date initiative of the care behaviors for the Resident # 8.	"Focus" it documented, "The tential of behavior problem r/t ions or hallucinations r/t (related and psychoactive medications." ons" it documented, "Monitor is and attempt to determine Consider location, time of day, and situations. Document as itated 12/15/2014." Further in plan failed to evidence targeted administration of Zyprexa to		29	
through 12/6/16 f evidence docume Resident # 8's be				
conducted with L 2 When asked v	20 p.m., an interview was PN (licensed practical nurse) # what behaviors were being sident # 8, LPN # 2 stated,			

"Behaviors that are out of the ordinary." When asked to clarify "Out of the ordinary." LPN # 2 was unable to provide specific targeted behaviors exhibited by Resident #8. On 12/7/16 at 1:15 p.m., an interview was

conducted with ASM (administrative staff member) #2, the director of nursing. When asked what behaviors were being monitored for Resident #8, ASM #2 stated, "The list of behaviors is listed on the med (medication) cart." An observation of the nurse's med cart was then conducted with ASM # 2. Tapped to the top of the med cart was a form entitled "Behavior Monthly Flow Sheet, December 2016." The behavior flow sheet documented behaviors and "Behavior Codes" numbering one to 38; "Intervention

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F 329	Codes" identified b W - Worsened." T documented, "Nambehavior flow shee of the resident, local specific behaviors, outcome codes. We were being monitor stated, "Any of the list of 38 behaviors sheet. ASM # 2 was specific behaviors? Resident # 8. On 12/7/16 at 5:35 member) # 1, the addirector of nursing, finding.	one to 11 and "Outcome y"I - Improved, S - Same and he behavior flow sheet also he, Location, Physician." The trailed to evidence the name ation, name of the physician, intervention codes and when asked which behaviors red for Resident #8, ASM #2 se behaviors" referring to the listed on the behaviors flow as unable to identify the that were be monitored for p.m. ASM (administrative staff administrator and ASM #2, the were made aware of these		329	
	schizophrenia (a m disturbed or unusu life, and strong or i adults and teenage is also used to trea depressive disorde episodes of depres other abnormal mo 13 years of age an class of medication antipsychotics. It w certain natural sub	used to treat the symptoms of mental illness that causes all thinking, loss of interest in nappropriate emotions) in ers 13 years of age and older. It is bipolar disorder (manic er; a disease that causes asion, episodes of mania, and bods) in adults and teenagers disorder. Olanzapine is in a mes called atypical yorks by changing the activity of stances in the brain. This obtained from the website:			

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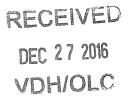
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https://medlineplus.gov/druginfo/meds/a601213.h

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	the esophagus and was obtained from	nts to leak back, or reflux, into irritate it. This information the website: a.gov/medlineplus/gerd.html.						
		nent disorder. This tained from the website: n.gov/medlineplus/parkinsonsdi						
	heartbeat. This info	the speed or rhythm of the ormation was obtained from a gov/medlineplus/atrialfibrillati						
	dominated by delus hallucinations. This from the website:	pe of schizophrenia is sions and/or auditory information was obtained gov/ency/imagepages/17236.						
	occurs with certain thinking, language, information was ob	oss of brain function that diseases. It affects memory, judgment, and behavior. This tained from the website: .gov/ency/article/000739.htm.						
	medications called Zyprexa is used to apathy	apine) is one of a group of atypical antipsychotics. control delusional thinking, erapy.org/blog/psychpedia/ap						

Facility ID: VA0028

athy>, strong emotions, and other symptoms that may accompany schizophrenia experienced by adults and teenagers over the age of 13. This information was obtained from the website:

DEPARTMENT OF HEALTH AND HUN. SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	pine.html. 483.80(a)(1)(2)(4)(e) PREVENT SPREA (a) Infection prevent The facility must est and control program a minimum, the foll (1) A system for present investigating, and communicable disevolunteers, visitors providing services arrangement based conducted accordinaccepted national simplementation is Fig. (2) Written standar for the program, whimited to: (i) A system of survices they can spifacility; (ii) When and to whom the communicable diserported; (iii) Standard and the communicable diserported;	e)(f) INFECTION CONTROL, D, LINENS Intion and control program. Istablish an infection prevention in (IPCP) that must include, at owing elements: Eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual diupon the facility assessmenting to §483.70(e) and following standards (facility assessment Phase 2); Ids, policies, and procedures inch must include, but are not really diseases or infections read to other persons in the ease or infections should be ransmission-based precautions	F 32	F. 441 483.80(a)(1)(2)(4)(e)(tion will be ents found to have at practice. ed by the lab or no so stated on the viewed and trol logs from Jan. ill identify other al to be affected by the 16 of infection e added. Any issues tumentation were all be put into place of ensure that the
	to be followed to pr	revent spread of infections;			

(iv) When and how isolation should be used for a

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					The nursing staff received refr	esher training
F 441	Continued From pa	ige 7	F	111	conducted by the Director of N	•
	resident; including				thoroughly review lab reports	•
		C. T. H. Carletter			• •	•
	(A) The type and di	uration of the isolation, e infectious agent or organism			for adding N/A or the specific	•
	involved, and	e micellous agent of organism			infection control log when app	olicable). Refreshe
	(B) A requirement t	hat the isolation should be the ssible for the resident under the			training for infection control loon 12/16/16.	og was completed
	must prohibit emplo disease or infected contact with reside	ces under which the facility oyees with a communicable skin lesions from direct nts or their food, if direct			4. Indicate how the facility pla performance to make sure that sustained.	
	contact will transm	it the disease; and			The Director of Nursing, or des	signee, will audit
	(vi) The hand hygie by staff involved in	ene procedures to be followed direct resident contact.			the infection control logs on a confirm there is documentation	weekly basis to
	(4) A system for re under the facility's actions taken by th	cording incidents identified IPCP and the corrective e facility.			either N/A or the specific orga identified during the audit pro coaching and corrective action	cess, then
	(e) Linens. Persor process, and trans spread of infection	nnel must handle, store, port linens so as to prevent the			The Director of Nursing or des the results of the weekly audit	•
	annual review of its	The facility will conduct an s IPCP and update their sary.			Assurance and Performance In Meetings for 3 months.	nprovement
	This REQUIREME by: Based on staff into	NT is not met as evidenced erview and facility document mined that the facility staff			At the conclusion of the three committee will re-evaluate an necessary action or extend the	d initiate any

November 2016.

failed to maintain an effective infection control program as evidenced by incomplete monthly infection logs from January 2016 through

The facility monthly infection logs from January

necessary action or extend the review period.

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TAG	Continued From paragraph 2016 through Nove and failed to docum for infection culture. The findings include A review of the more January 2016 through conducted. The following January 2016: 15 in Four documented to but only three documented to but only two docum identified. April 2016: 18 infect documented that conly four documented but only four documented but only two docum July 2016: 12 infect Three documented but only two docum July 2016: Ten infect Three documented but only one docum August 2016: 17 in Three documented but only two docum September 2016: 15	mber 2016 were incomplete nent the organisms identified is that were obtained. e: Inthly facility infection logs from agh November 2016 was owing was documented: Infections were documented, hat cultures were completed mented the organism that was in infections were documented, hat cultures were completed mented the organism that was bettons were documented. Six cultures were completed but the organism identified, were documented. It that cultures were completed mented the organism identified cotions were documented. It that cultures were completed mented the organism identified fections were documented. It that cultures were completed mented the organism identified fections were documented. It that cultures were completed mented the organism identified mented the organism identified.	F 4	The Skilled Nursing Adminis	strator is responsible ation and ongoing onents of this Plan of and resolving corrective action will
	were completed buorganism identified November 2016: 1	it only five documented the			

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identified.

but only three documented the organism

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BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANOT CORRECTION SHOULD BE PREFIX TAG F 441	NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX PREF						ECTED COPY
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 441 Continued From page 9 During the end of day interview on 12/7/16 at 5:40 P.M. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, the concern of the lacking information on the Infection Control Logs was reviewed. During an interview on 12/8/16 at 8:45 a.m. with ASM # 2 the missing laboratory results identifying the "organism" on the infection control logs was again reviewed. ASM # 2 stated that they never give antibiotics unless they have the culture results. ASM # 2 stated that she is responsible for overseeing the program. When asked the purpose of tracking infections in the building, ASM # 2 stated that the logs are used to track and trend infections in the building, and to determine what staff education is needed if they see a rise in certain types of infections. Review of the facility policy, "Infection Prevention & Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with CDC. The Center for Disease Control (CDC) www.cdc.gov http://www.cdc.gov may be used	BELVOIR	WOODS HEALTH CA	ARE CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060	
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P.M. with ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, the concern of the lacking information on the Infection Control Logs was reviewed. During an interview on 12/8/16 at 8:45 a.m. with ASM # 2 the missing laboratory results identifying the "organism" on the infection control logs was again reviewed. ASM # 2 stated that they never give antibiotics unless they have the culture results. ASM # 2 stated that she does not complete the logs but stated that she is responsible for overseeing the program. When asked the purpose of tracking infections in the building, ASM #2 stated that the logs are used to track and trend infections in the building and to determine what staff education is needed if they see a rise in certain types of infections. Review of the facility policy, "Infection Prevention & Control Program" documented, "It is the community's policy to maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with CDC. The Center for Disease Control (CDC) www.cdc.gov http://www.cdc.gov may be used	F 441	Continued From pa	ge 9	F 44	41	
to support the Infection Control Program." Under "Procedure: 1. The Director of Nursing oversees the overall Infection Control Program6. The Infection Control Nurse/designee collects and analyses surveillance data, and make		P.M. with ASM (adr the administrator, a nurses, the concert the Infection Control During an interview ASM # 2 the missing the "organism" on the again reviewed. As give antibiotics unleaded the purpose building, ASM # 2 stomplete the logs by the responsible for overasked the purpose building, ASM #2 stomplete the logs by the facility and the purpose building, ASM #2 stomplete the facility and the facility and the facility and community's policy Control Program designatory, and comfort help prevent the definition of the Center for Disease and infection Control Notes and the facility and composite the life of the center for Disease and infection Control Notes and the coverall Infection Infection Control Notes and the co	ministrative staff member) # 1, and ASM # 2, the director of n of the lacking information on all Logs was reviewed. To on 12/8/16 at 8:45 a.m. with a laboratory results identifying the infection control logs was SM # 2 stated that they never east they have the culture tated that she does not out stated that she is reseing the program. When of tracking infections in the tated that the logs are used to ections in the building and to aff education is needed if they in types of infections. Typolicy, "Infection Prevention of documented, "It is the to maintain an Infection esigned to provide a safe, ortable environment and to evelopment and transmission ction in accordance with CDC. Ease Control (CDC): They would be used at the control Program." Under the Director of Nursing oversees a Control Program6. The curse/designee collects and			

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Performance Improvement Committee....8. The Director of Nursing/Infection Control Nurse: a. Monitors the effectiveness of the Infection Control

Event ID: P9QO11

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DEPARTMENT OF HEALTH AND HUN **SERVICES**

PRINTED: 12/15/2016 FORM APPROVED

	OCCOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		495197	B. WING		12/08/2016
NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
DEL VOIE	WOODS HEALTH C	ARE CENTER AT THE FAIRFAX	1		CTED COPY
BELVOIR	WOODS HEALIN C	ARE CENTERAL THE FAIRTAX	F	FORT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
				F. 465 483.90 (h)(5)	
F 441			F 441	SAFE/FUNCTIONAL/SANITAR	Y/COMFORTABLE
	Program b. Evalua	tes infection control		ENVIRONMENT	
	compliance and sta	an practices ion was provided prior to exit.			
F 465	483 90(h)(5)		F 465	1. Address how corrective act	ion will be
SS=D	SAFE/FUNCTION	AL/SANITARY/COMFORTABL		accomplished for those reside	nts found to have
	E ENVIRON			been affected by the deficient	practice.
	(h) Other Environm	ental Conditions		A	
				At the time of survey, the aero	
	The facility must pr	ovide a safe, functional, ortable environment for		removed and placed in the du	mpster.
	residents, staff and	I the public.		2. Address how the facility wil	l identify other
	(1.)(E) E (-1.)(-1.)	liaina in accordance with		residents having the potential	•
	(h)(5) Establish pol applicable Federal	licies, in accordance with , State, and local laws and		the same deficient practice.	to be directed by
	regulations, regard	ing smoking, smoking areas,		the same dentient practice.	
		y that also take into account		The six public guest and reside	ent bathrooms
	non-smoking resid	NT is not met as evidenced		were inspected on 12/8/16 by	the Director of
	bv:			Nursing and the Director of Ho	ousekeeping and
	Based on observa	ation, staff interview and facility he facility staff failed to ensure		no other aerosol cans or chem	. •
	chemicals were lo	cked in a cabinet for one of six			ais were round.
	facility resident bat	hrooms, (Ash Neighborhood		3. Address what measures wil	l be put into place
	unit resident bathro	oom).		or systemic changes made to	ensure that the
	One six ounce aer	osol can of air freshener		deficient practice will not recu	ır.
	available for use w	as found in an unlocked			
		Neighborhood unit resident		Staff received refresher training	•
	bathroom.			the Director of Nursing, or des	signee, on
	The findings include	de:		12/16/16 regarding the impor	tance and process
	0= 40/0/46 of con-	rovimately 10:20 a m an		for securing chemicals, how to	address families
	observation was m	roximately 10:20 a.m., an hade of the facility's resident		that wish to bring in air freshe	ner or cleaning

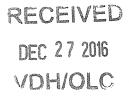
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bathroom on the "Ash Neighborhood" unit with OSM (other staff member) # 4, director of engineering. Upon opening the unlocked cabinet

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DEPARTMENT OF HEALTH			<u> </u>	FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES		(<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
				С
	495197	B. WING		12/08/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			9160 BELVOIR WOODS PKWY CORRI	ECTED COPY
BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			FORT BELVOIR, VA 22060	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CONTROL TO THE APPROPRIATE DEFICIENCY)		D BE COMPLETION
(197, 201, 201, 201, 201, 201, 201, 201, 201			products, and how to report a	and resolve a lack
F 465 Continued From page 11 under the bathroom sink revealed a small basket containing paper towels and a six ounce aerosol can of air freshener. OSM # 4 stated, "It shouldn't be here. This product is not provided by our vendor, it must have been brought in by someone." ASM (administrative staff member) # 2, director of nursing, was then asked to come to		F 4	65 of compliance.	
		In addition, a letter was sent to reside families on 12/16/16 reminding them protocols regarding chemical and clear product usage, storage, and the necess		ng them of the and cleaning

The label on the aerosol can of air freshener found in the facility's resident bathroom on the Ash Neighborhood documented, "Caution: Eye irritant. May be harmful if directly inhaled. May cause allergic reaction in some individuals."

the resident bathroom on the "Ash Neighborhood"

should have been checked by housekeeping and nursing." After examining the aerosol can OSM #

then removed the aerosol can from the bathroom.

4 stated, "The can is about half full." OSM # 4

unit. After observing the basket with the six

ounce aerosol can of air freshener ASM # 2 stated. "It shouldn't be here. The bathroom

On 12/8/16 at approximately 11:15 a.m. an interview was conducted with OSM # 3, director of housekeeping, regarding the aerosol can of air freshener that was found in the facility's resident bathroom on the Ash Neighborhood unit. OSM # 3 stated that the air freshener was not the type used by the facility and it must have been brought in by someone. When asked if the housekeepers check the bathrooms for items that don't belong there OSM # 3 stated, "They're supposed to."

On 12/8/16 at approximately 11:20 a.m. an interview was conducted with ASM # 2 regarding the aerosol can of air freshener that was found in the facility's resident bathroom on the Ash Neighborhood unit. ASM # 2 stated, "We let the families and residents know not to bring in

community using commercial products that are

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

designed for a health care setting.

The Administrator, or designee, will inspect the six public guest and resident bathrooms on a weekly basis. If issues are identified during the audit process, then coaching, and corrective action will occur.

The Administrator or designee will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months.

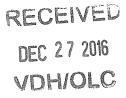
At the conclusion of the three months, the QAPI committee will re-evaluate and initiate any necessary action or extend the review period.

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Event ID: P9QO11



DEPARTMENT OF HEALTH AND HULL SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039						
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED		
	495197	B. WING		C 12/08/2016		
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODCHEALTH C	ADE CENTED AT THE EAIDEAY		9160 BELVOIR WOODS PKWY CORRE	CTED COPY		
WOODS HEALTH C	ARE CENTER AT THE FAIRTAX		FORT BELVOIR, VA 22060			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION		
			The Skilled Nursing Administra	tor is responsible		
	_	F 4	¹⁶⁵ for monitoring implementation	n and ongoing		
he checking the ba	sing and nousekeeping should throoms on a daily basis for		compliance with the compone	nts of this Plan of		
aerosols."	,		Correction and addressing and	resolving		
During the days of	the resident bathroom on the		variances that may occur.			
observed entering			5 Include dates when the corr	ective action will		
"Ash Neighborhood				cetive action will		
The facility policy "Chemical Safety: Resident			se completed.			
must take the appr	opriate precautions to		All corrective actions complete	d by 1/6/17.		
combination of dilic	gent monitoring, proper					
chemical-selection	, safe dispensing systems,					
proper usage and restricted access to authorized						
On 12/7/16 at 5:35	n m ASM (administrative staff					
member) # 1, the a	idministrator, and ASM # 2, the					
director of nursing,	were made aware of these					
finding.						
No further informat	ion was provided prior to exit.					
483.70(i)(1)(5) RES		F	514			
RECORDS-COMP	LETE/ACCURATE/ACCESSIB					
(i) Madical records						
(1) In accordance v	with accepted professional					
standards and prac	ctices, the facility must					
	ecords on each resident that					
ai C-						
(i) Complete;						
	ROVIDER OR SUPPLIER WOODS HEALTH C. SUMMARY STA (EACH DEFICIENCY REGULATORY OR L. Continued From pa aerosol cans. Nurs be checking the ba aerosols." During the days of observed entering "Ash Neighborhood The facility policy "(Risk Reduction" do must take the appr minimize resident's and other hazardou combination of dilig chemical-selection proper usage and r team members in a (Name of Facility's) On 12/7/16 at 5:35 member) # 1, the a director of nursing, finding. No further informat 483.70(i)(1)(5) RES RECORDS-COMP LE (i) Medical records (1) In accordance v standards and prac maintain medical re are-	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197 ROVIDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 aerosol cans. Nursing and housekeeping should be checking the bathrooms on a daily basis for aerosols." During the days of the survey, resident were not observed entering the resident bathroom on the "Ash Neighborhood" unit. The facility policy "Chemical Safety: Resident Risk Reduction" documented, "Communities must take the appropriate precautions to minimize resident's risk of injury from chemicals and other hazardous materials through a combination of diligent monitoring, proper chemical-selection, safe dispensing systems, proper usage and restricted access to authorized team members in a manner that is consistent with (Name of Facility's) Principles of Service." On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of these finding. No further information was provided prior to exit. 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA BUILD 495197 B. WING ROVIDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 aerosol cans. Nursing and housekeeping should be checking the bathrooms on a daily basis for aerosols." During the days of the survey, resident were not observed entering the resident bathroom on the "Ash Neighborhood" unit. The facility policy "Chemical Safety: Resident Risk Reduction" documented, "Communities must take the appropriate precautions to minimize resident's risk of injury from chemicals and other hazardous materials through a combination of diligent monitoring, proper chemical-selection, safe dispensing systems, proper usage and restricted access to authorized team members in a manner that is consistent with (Name of Facility's) Principles of Service." On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of these finding. No further information was provided prior to exit. 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	OCO DEFICENCIES FORRECTION (X1) PROVIDER SUPPLIER 495197 ROVIDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 12 aerosol cans. Nursing and housekeeping should be checking the bathrooms on a daily basis for aerosols." During the days of the survey, resident were not observed entering the resident bathroom on the "Ash Neighborhood" unit. The facility policy "Chemical Safety. Resident Risk Reduction" documented, "Communities must take the appropriate precautions to minimize residents risk of injury from chemicals and other hazardous materials through a combination of diligent monitoring, proper chemical-selection, safe dispensing systems, proper usage and restricted access to authorized team members in a manner that is consistent with (Name of Facility's) Principles of Service." On 12/7/16 at 5:35 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of these finding. No further information was provided prior to exit. 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-		

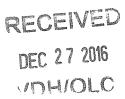
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(ii) Accurately documented;

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DEPARTMENT OF HEALTH AND HUN. . SERVICES

PRINTED: 12/15/2016 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495197	B. WING		C 12/08/2016
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY CORREC FORT BELVOIR, VA 22060	CTED COPY
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ACARA DEFENDENCES TO THE ADDROD	D BE COMPLETION
F 514 Continued From pa	age 13	F 5	F. 514 483.70(i)(1)(5) RESIDE COMPLETE/ACCURATE/ACCES	
(iii) Readily access	ible ⁻ and		1 Address how corrective act	ion will bo

- (iv) Systematically organized
- (5) The medical record must contain-
- (i) Sufficient information to identify the resident;
- (ii) A record of the resident's assessments;
- (iii) The comprehensive plan of care and services provided:
- (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
- (v) Physician's, nurse's, and other licensed professional's progress notes; and
- (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced

Based on clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 16 residents in the survey sample, Resident #7.

The facility staff failed to accurately document Resident # 7's allergies on the current POS (physician's order sheet).

The findings include:

Resident # 7 was admitted to the facility on 12/10/13 and a readmission of 12/10/15 with diagnoses that included but were not limited to:

 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

At the time of survey, the Director of Nursing updated the Physician Order Sheet of resident # 7 to correctly indicate the appropriate allergy and informed the pharmacy of the error in the system, so that the POS could be updated.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

On 12/8/16, the Director of Nursing conducted an audit of residents medical records to confirm that identified allergies were reflected on the Physician Order Sheet. No issues were identified.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

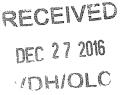
On 12/16/16, The Director of Nursing conducted refresher training for nurses on Physician Order Sheets and medical records mandating the

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SERVICES DEPARTMENT OF HEALTH AND HUN.

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CENTERS FOR MEDICARE & MEDICAID SERVICES					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495197	B. WING		C 12/08/2016	
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH C.	ARE CENTER AT THE FAIRFAX	9	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY CORRECTED COPY FORT BELVOIR, VA 22060		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONCRESS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 514 Continued From pa	age 14	F 514	necessity of resident allergies. Nursing, or designee will moni		

macular degeneration (1), benign prostatic hyperplasia (2), hypertension (3), dysphagia (4), and pain.

> Resident # 7's most recent MDS (minimum dada set) a quarterly assessment with an ARD (assessment reference date) of 9/13/16 coded the resident as scoring a 13 on the brief interview for mental status (BIMS) of a score of 0 - 15, 13 being cognitively intact for daily decision making. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living.

> Review of Resident #7's clinical record revealed a sticker on the inside cover of the clinical record. The sticker documented, "Allergies: Percocet (5)."

> The POS (physician's order sheet) for Resident # 7 dated December 2, 2016 documented, "Allergies: No Known Allergies."

On 12/7/16 at 8:35 a.m. an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After being asked to review Resident # 7's clinical record ASM # 2 was asked to identify Resident # 7's allergies. ASM # 2 identified the sticker on the inside of the clinical record that documented, "Allergies: Percocet," and the current physician's order dated December 2, 2016 that documented, "Allergies: "No Known Allergies." ASM # 2 stated, "I'll check the system to clarify it." After checking the electronic health record ASM # 2 stated, "The physician's order sheet is not correct. The pharmacy didn't pick it up. I'm doing a clarification now."

of allergies on Physician Order Sheets and medical records on a monthly basis.

> 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Director of Nursing, or designee, will audit accuracy of Physician Order Sheets and medical records for appropriate allergies for new admissions and on a monthly basis.

If issues are identified during the audit process, then coaching, and corrective action will occur.

The Director of Nursing, or designee, will report the results of the weekly audit at the Quality Assurance and Performance Improvement Meetings for 3 months.

At the conclusion of the three months, the Quality Assurance Performance Improvement committee will re-evaluate and initiate any necessary action or extend the review period.

The Skilled Nursing Administrator is responsible for monitoring implementation and ongoing compliance with the components of this Plan of

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DEPARTMENT OF HEALTH AND HUN . SERVICES

PRINTED: 12/15/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					0	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDIENTO	, 00111.2011011		A. BUILDII			С
		495197	B. WING			12/08/2016
NAME OF F	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	
BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			916	0 BELVOIR WOODS PKWY CORREC	CTED COPY	
BELVOIR	WOODS HEALTH CA	ARE CENTER AT THE PAINFAX		FO	RT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
					Correction and addressing and	l resolving
F 514	Continued From pa	ige 15	F 514 variances that may occur. 5. Include dates when the corrective action be completed.			Ü
		a.m. ASM # 2 provided this				
	surveyor with a cop	by of the physician's order sident # 7 dated 12/7/2016.				ective action will
	The POS documen	ited, "Allergies: Oxycodone."				
	On 12/7/16 at 11:20 a.m. an interview was conducted with ASM # 4, physician. When asked about the potential side effects if Resident # 7 was administered Percocet, ASM # 4 stated, "There could be drowsiness, loss of appetite and constipation."			,	All corrective actions complete	ed by 1/6/17.
	member) # 1, the a	p.m. ASM (administrative staff administrator and ASM # 2, the were made aware of these				
	No further informat	ion was provided prior to exit.				
	Reference:					
	vision. You need co clearly and to do ta driving. This information website:	destroys your sharp, central entral vision to see objects asks such as reading and nation was obtained from the .gov/maculardegeneration.htm				
	obtained from the	ostate. This information was website: n.gov/medlineplus/enlargedpro				
	(3) High blood pres	ssure. This information was website:				

FORM CMS-2567(02-99) Previous Versions Obsolete

essure.html.

https://www.nlm.nih.gov/medlineplus/highbloodpr

Event ID: P9QO11

Facility ID: VA0028

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